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	445145	A. BUILDING _____ B. WING _____	03/06/2013

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F 000	INITIAL COMMENTS During the annual recertification survey and complaint investigation numbers 28917, 30653, and 30268, conducted on March 4-6, 2013, at Golden Livingcenter Mountain View, no defiiciencies were cited in relation to the complaints under 42 CFR PART 483.13, Requirements for Long Term Care.	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to assess for the use of a restraint for one resident (#123) of thirty-nine residents reviewed. The findings included: Resident #123 was admitted to the facility on September 12, 2012, with diagnoses including Depression, Manic Disorder, Anxiety, and Dementia with Behaviors. Medical record review of the quarterly Minimum Data Set (MDS) dated December 20, 2012, revealed the resident had long and short term memory problems, required extensive assistance of two for bed mobility, and physical restraints were not used.	F 221	1. A side rail assessment was completed for Resident #123 resulting in side rails removal, bed placed in low position and bolsters implemented. 2. All residents within the facility have the potential to be affected. All residents using side rails will be reassessed for appropriateness with side rail reduction initiated as indicated. 3. a) On 03/15/13, the Executive Director and Director of Nursing reviewed the facility's policy regarding side rail usage. b) All direct care staff were re-educated by the Director of Clinical Education regarding appropriate usage of side rails. 4. The Director of Nursing will ensure compliance by conducting weekly walking rounds observing side rail usage with findings reported monthly to the QA Committee x 3 months.	4/19/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Vicki Lee Goodwin	Executive Director	3/26/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 2 station, revealed the resident did not use the side rails for turning and repositioning. Interview with the Director of Nursing (DON) on March 6, 2013, at 8:09 a.m., in the nurse's station, revealed the side rails defined the parameters of the bed for the resident, and if the side rails were not used the resident would exit the bed. Interview with the Corporate Nurse on March 6, 2013, at 9:30 am, in the Human Resource Office, confirmed no assessment had been completed for the use of side rails as a restraint.	F 221		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide activities for one resident (#123) of thirty-nine residents reviewed. The findings included: Resident #123 was admitted to the facility on September 12, 2012, with diagnoses including Depression, Manic Disorder, Anxiety, and Dementia with Behaviors.	F 248	1. On 3/07/13, the Activities Coordinator reassessed Resident #123 and developed an appropriate activities program. 2. All residents within the facility have the potential to be affected. All current residents will be reassessed to ensure an appropriate ongoing activities program is implemented. 3. a) On 3/06/13, the Executive Director and Activities Coordinator reviewed the facility's Recreational Services Program. b) All new residents will be assessed by the Activities Coordinator to ensure an appropriate ongoing activities program is implemented. c) Activities Coordinator will audit 5 new admissions per month by using the New Admissions Recreational Services Program audit tool to ensure an appropriate ongoing activities program is implemented with findings provided monthly to the Executive Director to monitor for continued compliance.	4/19/13

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F 248	Continued From page 3 Medical record review of the quarterly Minimum Data Set (MDS) dated December 20, 2012, revealed the resident had long and short term memory problems, and required extensive assistance with all Activities of Daily Living. Medical record review of the Care Plan revised on December 30, 2012, revealed "...sometimes display inappropriate behavior during group activities...offer me soothing activities for a calming effect...please include me in mainly in smaller groups...seat me near the door in case I need to leave the activity early...try activity interventions with me before I become very agitated..." Observation on March 5, 2013, at 4:30 p.m., in the hall, revealed the resident propelling self in the wheelchair. Interview with the resident's spouse on March 4, 2013, at 12:52 p.m., in the resident's room, revealed the facility had not provided activities for the resident. Interview with the Activity Coordinator on March 5, 2013, at 3:45 p.m., in the activity office, revealed no documentation the resident had attended or participated in the facility's activity program. Interview with the Director of Nursing on March 6, 2013, at 9:26 a.m., in the Human Resources Office, confirmed the facility failed to provide an activity program for the resident.	F 248	4. The Executive Director will audit 5 residents activities program per month by attending scheduled activities with findings reported monthly to the QA Committee x 3 months.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

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F 279	Continued From page 4 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to develop a plan of care to address community discharge for one resident (#95) and to revise or update the care plan for Range of Motion (ROM) for one resident (#123) of thirty-nine residents reviewed. The findings included: Resident #95 was admitted to the facility on December 21, 2012, with diagnoses including Manic Disorder, Depressive Disorder, and Dementia. Medical record review of the admission Minimum	F 279	1. a) On 3/07/13, the Social Services Director completed a discharge plan for Resident #95. b) On 3/07/13, the Director of Nursing completed a plan of care for Resident #123 ensuring decline in ROM had been revised. 2. a) All residents within the facility have the potential to be affected. The Social Services Director will review the medical record of all current residents to ensure a discharge plan had been addressed. b) All residents within the facility have the potential to be affected. The MDS Coordinator will review the care plan of current residents identified by direct care staff to have a decline in ROM to ensure revisions as appropriate. 3. a) Within 72 hours of admission Social Services Director will meet with all new admissions and/or their POA to complete an initial discharge plan. b) MDS Coordinator will ensure residents identified by direct care staff to have a decline in ROM will have a plan of care ensuring decline has been addressed and/or revised as appropriate. 4. a) Monthly the Executive Director will review the medical record of 5 new admissions to ensure a discharge plan had been completed with findings reported monthly to the QA Committee x 3 months. b) Weekly the Director of Nursing will review each newly identified resident having a decline in ROM to ensure the care plan had been revised as appropriate with findings reported monthly to the QA Committee x 3 months.	4/19/13

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F 279	Continued From page 5 Data Set (MDS) dated December 28, 2012, revealed the resident's overall goal established during the assessment process was unknown or uncertain, and there was no active discharge plan in place for the resident to return to the community. Medical record review of the Care Plan dated January 17, 2013, revealed no problem or approach to address discharge needs. Observation on March 6, 2013, at 8:10 a.m., revealed the resident lying on the bed, with the head of the bed elevated, eating breakfast. Interview on March 6, 2013, at 7:30 a.m., with the MDS Coordinator, in the conference room, confirmed the Care Plan did not address the resident's discharge needs. Resident #123 was admitted to the facility on September 12, 2012, with diagnoses including Depression, Manic Disorder, Anxiety, and Dementia with Behaviors. Medical record review of the admission Minimum Data Set (MDS) dated September 19, 2012, revealed no functional limitation of ROM in the lower extremities. Medical record review of the quarterly MDS dated December 20, 2012, revealed a functional limitation of ROM and impairment in the lower extremities. Medical record review of the PT (Physical Therapy) - Therapist Progress and Discharge Summary dated December 20, 2012, revealed	F 279		

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F 279	Continued From page 6 "...decreased ROM...Discharge Plans: (POC) (Plan of Care) Remain in SNF (Skilled Nursing Facility) with Restorative Nursing Program..." Medical record review of the Care Plan revised January 14, 2013, revealed "...Monitor and report changes in ROM ability..." Interview with MDS Coordinator (responsible for care plans) in the nurse's station, on March 5, 2013, at 3:17 p.m., confirmed the facility failed to revise or update the care plan to reflect the decline in ROM.	F 279		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility policy, observation, and interview, the facility failed to establish an individualized bladder training program for one resident (#104) of thirty-nine residents reviewed. The findings included:	F 315	1. On 3/11/13, the Director of Nursing began a Bowel and Bladder assessment implementing a three day tracking tool on Resident #104. 2. All residents have the potential to be affected. The Director of Nursing will reassess current residents implementing, where appropriate, a three day tracking tool to obtain a voiding pattern to determine an individualized urinary incontinence program 3. a) On 3/11/13, the Director of Clinical Education began re-education with direct care staff regarding the facility's Bowel and Bladder program to ensure continued compliance. b) Residents identified by direct care staff as having a decline in bladder functioning will have a three day tracking tool implemented by the charge nurse with the Assistant Director of Nursing monitoring for compliance and implementing an individualized bladder program when appropriate. c) All new admissions will have a three day tracking tool implemented by the admitting charge nurse with the Assistant Director of Nursing monitoring for compliance and implementing an individualized bladder program when appropriate.	4/19/13

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F 315	Continued From page 7 Resident #104 was admitted to the facility on September 27, 2012, with diagnoses including Hypertension, Dementia, and Hyperlipidemia. Review of the facility policy, "Incontinence Management/Bladder Function Guideline", revealed, "...Upon admission...complete the Bowel and Bladder Tracking Tool...Completed to identify any trends or patterns that the resident may have in relation to incontinence...3 full days completed...upon completion of this assessment/evaluation as well as the Tracking Tool, the toileting/bladder program can be determined..." Medical record review of the "Clinical Health Status" dated September 27, 2012, revealed "...Urinary Incontinence...Incontinent...Liners/Briefs used..." Medical record review of the Admission Minimum Data Set (MDS) dated October 4, 2012, revealed the resident was occasionally incontinent of urine. Medical record review of the Care Plan dated October 16, 2012, revealed, "...Alteration in elimination of bowel and bladder...Evaluate frequency/timing of incontinence episodes..." Medical record review of the Quarterly MDS dated January 14, 2013, revealed the resident was frequently incontinent of urine. Medical record review revealed no documentation a bladder tracking tool had been completed. Observation on March 5, 2013, at 4:30 p.m. revealed the resident seated in a wheelchair, in	F 315	4. a) Weekly the Director of Nursing will review each newly identified resident having a decline in bladder functioning to ensure a voiding pattern had been determined and an individualized urinary incontinence program had been established with findings reported monthly to the QA Committee x 3 months. b) Weekly the Director of Nursing will review each new admission to ensure a voiding pattern had been determined and an individualized urinary incontinence program, when appropriate, had been established with findings reported monthly to the QA Committee x 3 months.	

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F 315	Continued From page 8 the resident's room. Interview on March 5, 2013, at 4:45 p.m., in the conference room, with the Registered Nurse Clinical Consultant, confirmed a voiding pattern had not been obtained to determine an individualized urinary incontinence program.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide a restorative nursing program for Range of Motion (ROM) for one resident (#123) of thirty-nine residents reviewed. The findings included: Resident #123 was admitted to the facility on September 12, 2012, with diagnoses including Depression, Manic Disorder, Anxiety, and Dementia with Behaviors. Medical record review of the admission Minimum Data Set (MDS) dated September 19, 2012, revealed no functional limitation of ROM in the lower extremities.	F 318	1. A restorative nursing program was implemented on Resident #123. 2. All residents within the facility discharged from rehabilitation services receiving a nursing referral for ROM have the potential to be affected. Current residents discharged from a rehabilitation service receiving a restorative nursing referral for ROM have been placed in an appropriate program. 3. a) On 3/7/13, the Executive Director re-educated the Rehabilitation Program Coordinator regarding the requirement to provide a restorative nursing referral for residents requiring an appropriate program. b) Rehabilitation Program Coordinator will provide Interdisciplinary team with restorative nursing referrals 5 days per week with continued compliance monitored by the Director of Nursing. 4. Weekly the Director of Nursing will review each resident discharged from a rehabilitation service receiving a restorative nursing referral for ROM to ensure placement in an appropriate program with findings reported monthly to the QA Committee x 3 months.	4/19/13

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F 318	Continued From page 9	F 318		

Medical record review of the quarterly MDS dated December 20, 2012, revealed a functional limitation of ROM and impairment in the lower extremities.

Medical record review of the PT (Physical Therapy) - Therapist Progress and Discharge Summary dated December 20, 2012, revealed "...decreased ROM...Discharge Plans: (POC) (Plan of Care) Remain in SNF (Skilled Nursing Facility) with Restorative Nursing Program..."

Medical record review of the Care Plan revised January 14, 2013, revealed "...Monitor and report changes in ROM ability..."

Observation on March 4, 2013, at 12:52 p.m., in the resident's room, revealed the resident lying on the bed.

Interview with the MDS Coordinator on March 5, 2013, at 3:17 p.m., in the nurse's station, revealed the resident had been assessed on December 20, 2012, and a decline in ROM in the resident's lower extremities had been noted. Continued interview revealed the MDS Coordinator had not reported the decline in ROM for the resident, and the resident had been discharged from PT on December 20, 2012.

Interview with Certified Nurse Technician (CNT) #2 on March 5, 2013, at 4:45 p.m., in the nurse's station, revealed the resident had not been placed on the restorative program.

Interview with the Registered Physical Therapist (RPT) on March 6, 2013, at 9:18 a.m., in the

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F 318	Continued From page 10 Human Resource (HR) Office, revealed on December 13, 2012, the resident had an analysis of ROM. Continued interview revealed the analysis revealed during exercises the resident showed a decreased tolerance to exercise, decreased ROM, and decreased tolerance to transfers. Further interview at this time revealed the resident had been discharged from PT on December 20, 2012, a referral for restorative nursing had been the plan and the RPT had not followed up. Interview with the Director of Nursing on March 6, 2013, at 9:25 a.m., in the HR Office, confirmed the facility failed to provide a Restorative Nursing Program.	F 318		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility policy, observation, and interview, the facility failed to prevent significant weight loss for one resident (#104) of thirty-nine residents	F 325	1. Registered Dietician (RD) completed a dietary assessment for Resident #104. 2. All residents within the facility have the potential to be affected. The Registered Dietician completed an audit of current residents with significant weight loss to ensure an assessment had been completed with no others identified as missing. 3. a) On 3/06/13, the Executive Director re-educated the Registered Dieticians on the F325 regulation. b) Residents with significant weight loss will have a dietary assessment completed by the Registered Dietician. c) Residents with significant weight loss will be reviewed weekly by the Director of Nursing and the Interdisciplinary team to ensure a dietary assessment has been completed. 4. Weekly the Director of Nursing will review residents with significant weight loss to ensure an assessment had been completed by the Registered Dietician with findings reported monthly to the QA Committee x 3 months.	4/19/13

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F 325	Continued From page 11 reviewed. The findings included: Resident #104 was admitted to the facility on September 27, 2012, with diagnoses including Hypertension, Dementia, and Hyperlipidemia. Medical record review of the weight record revealed the resident's weight on September 27, 2012, was 137 pounds. Medical record review of the Nutrition Assessment dated October 10, 2012, revealed, "...Current Weight 137 (pounds)...IBW (Ideal Body Weight) Range 126-154 (pounds)..." Medical record review of the weight record revealed the resident's weight on October 25, 2012, was 129 pounds (5.8 percent weight loss in 30 days). Medical record review revealed no Registered Dietician (RD) assessment of the significant weight loss. Medical record review of the Nutrition Assessment dated January 22, 2013, revealed, " ...Current Weight 134 (pounds) ...Pt (patient) feeds self...in Dining Room...loss of 7.2% (percent) between Oct and Nov, Dec 127 (pounds) and gain to...134 (pounds)..." Review of the facility policy, Weight Monitoring, revealed, "...All weights will be reviewed...and the RD will be notified of any significant weight changes or trends through the referral process..."	F 325		

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F 325	Continued From page 12 Observation on March 4, 2013, at 8:30 a.m., revealed the resident seated in a wheelchair, in the dining room, eating breakfast. Interview on March 5, 2013, at 4:35 p.m., in the front hall, with the Administrator, confirmed the RD had not reviewed the resident's significant weight loss from September 27, 2012 to October 25, 2012.	F 325		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431	1. On 3/05/13, vacutainer tubes with expired dates were disposed. 2. All residents within the facility have the potential to be affected. The Director of Nursing and Assistant Director of Nursing checked all med storage areas with no other items found to be expired. 3. a) The Central Supply Clerk was re-educated by the Director of Nursing on monitoring for expiration dates. b) Weekly the Assistant Director of Nursing will check all med rooms to ensure no items are expired with findings reported to the Director of Nursing. c) Weekly the Central Supply Clerk will check the OTC med room to ensure no items are expired with findings reported to the Director of Nursing. 4. Monthly the Director of Nursing will check all med rooms for expired items with findings reported monthly to the QA Committee x 3 months.	4/19/13

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	445145	A. BUILDING _____ B. WING _____	03/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MOUNTAIN VIEW	1360 BYPASS ROAD WINCHESTER, TN 37398

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F 431	Continued From page 13 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure biologicals were not expired and available for resident use, in one of three medication rooms reviewed. The findings included: Observation on March, 5, 2013, at 7:55 a.m., in the OTC (over the counter) Medication Storage Room revealed, an open box of twenty four blue top vacutainer tubes (tubes used to obtain blood samples for lab testing for blood clotting times) with an expiration date of January, 2013. Continued observation revealed, a sealed box of 48 red top vacutainer tubes (used to collect blood samples for drug levels and blood chemistry tests) with an expiration date of January 2013, present. Interview with the Central Supply Clerk, on March 5, 2013, at 8:04 a.m., in the OTC medication room, confirmed the vacutainer tubes were available for use, and were expired.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		

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F 441	Continued From page 14 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility	F 441	1. On 3/06/13, the Director of Nursing re-educated CNT #1 regarding the facility's isolation policy and procedure for droplet precautions. 2. All residents within the facility on isolation have the potential to be affected. Residents currently on isolation have been reassessed to ensure isolation policy and procedure for droplet precautions are implemented. 3. a) On 3/07/13, the Director of Clinical Education began re-educating all facility staff regarding the facility's isolation policy and procedure for droplet precautions. b) All residents on isolation will have isolation protocol followed per facility policy with monitoring by the Director of Nursing through walking rounds observing staff entering and exiting isolation rooms. 4. Weekly walking rounds observing staff entering and exiting isolation rooms will be conducted by the Director of Nursing with findings reported monthly to the QA Committee x 3 months.	4/19/13

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F 441	Continued From page 15 policy, observation, and interview, the facility failed to follow infection control practice for one resident (#32) of thirty-nine residents reviewed. The findings included: Resident #32 was admitted to the facility on September 27, 2012, with diagnoses including Aphasia, Cerebrovascular Disease, and Dysphagia. Medical record review of a laboratory test dated March 3, 2013, revealed the resident had tested positive for influenza. Medical record review of a Nurse Progress Note dated March 6, 2013, revealed "...Cont (continues) on isolation for flu with staff wearing gloves, gowns, and mask..." Review of facility policy dated October 2009, revealed "...Droplet Precautions...examples of infections requiring Droplet Precautions...Influenza...wear a mask...the facility utilizes the following system for identification of Droplet Precautions yellow..." Observation on March 4, 2013, at 6:06 a.m., in the lower B-Hall, revealed a yellow sign on the resident's door "...Check at Nurse's Station before entering..." Observation on March 4, 2013, at 6:07 a.m., in the lower B-Hall, revealed Certified Nurse Technician (CNT) #1 entered the resident's room with no mask. Further observation revealed the CNT exited the room with no mask.	F 441		

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F 441	Continued From page 16 Interview with CNT #1 on March 4, 2013, at 6:10 a.m., in the lower B-Hall, confirmed the CNT entered the isolation room without wearing a mask, and did not know the type of isolation precautions in place for the resident. Interview with Licensed Practical Nurse (LPN) #1 on March 4, 2013, at 6:15 a.m., in the lower B-Hall, revealed the resident had been in isolation for the flu. Interview with the Director of Nursing on March 6, 2013, at 8:00 a.m., in the nurse's station, confirmed the employees were instructed on the droplet isolation precautions. Continued interview confirmed the CNT failed to follow the facility's isolation policy for Droplet Precautions.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to obtain a laboratory specimen for one resident (#49) of thirty-nine residents reviewed. The findings included: Resident #49 was admitted to the facility with diagnoses including Vascular Dementia, Depressive Disorder, Hypertension, Anxiety Disorder, and Alzheimer's Disease.	F 502	1. On 3/05/13, the Licensed Practical Nurse in the Alzheimer's Unit notified Resident #49's physician and received an order to obtain a Depakote level with level drawn and within range. 2. All residents within the facility receiving Depakote have the potential to be affected. Current residents receiving Depakote have had orders reviewed over the past 30 days to ensure any lab levels were completed per physician's order. 3. a) On 3/06/13, the Director of Nursing re-educated the LPN responsible for original order transcription. b) On 3/07/13, the Director of Clinical Education began re-educating licensed staff regarding the facility's laboratory process and redlining protocol to ensure new orders are noted. c) Compliance will be monitored by the Director of Nursing through the daily Clinical Start Up process.	4/19/13

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F 502	Continued From page 17 Medical record review of a Physican's Order dated December 13, 2012, revealed "...Depakote (anticonvulsant, antimanic) 250 mg (milligrams) 1 po (by mouth) bid (twice a day) (check) depakote level in 3 weeks...(due January 3, 2013)" Medical record review revealed no laboratory report for the depakote level. Medical record review of a laboratory report dated March 5, 2013, revealed "...Valproic Acid (Depakote)...Result 38...Reference 50-100..." Interview on March 5, 2013, at 1:20 p.m., in the Alzheimer Unit nursing station, with Licensed Practical Nurse #1,confirmed the depakote level for January had not been obtained as ordered by the physician.	F 502	4. The Director of Nursing will ensure compliance by monitoring of lab orders during the daily Clinical Start Up process with findings reported monthly to the QA Committee x 3 months.	